

## Midwifery Scope of Practice Comments

### April 3 through April 9 2013

<p><b>1. The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I have read over the ACOG Bulletin which came out in response to the NIH final statements which can be viewed here if not already looked over (<a href="http://consensus.nih.gov/2010/vbacstatement.htm">http://consensus.nih.gov/2010/vbacstatement.htm</a>). although FTP/CPD may not have the highest success rate for giving birth vaginally after the previous c-section the number is not zero either, there is a decent percent that are successful depending on region 40-50% of the primary csections have this diagnosis. the successful vbac rate is something like 55% compared to 67% for other causes . so not too bad, maybe some transfer of care in labor for FTP but not all</p>	<p>Tue, Apr 9, 2013</p> <p>11:23 PM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I would like to take a moment to thank Director Humble and everyone involved in this project for coming into this it with an open mind. I have been very impressed with the time given to this issue and what I'm sure are endless hours pouring over information and rewriting the scope of practice. I have been the Chapter Leader for ICAN of Phoenix for about 3 years now. ICAN is the International Cesarean Awareness Network (<a href="http://www.ican-online.org">www.ican-online.org</a>) and our focus is on giving support to women who have had cesareans and helping women find resources, support and information to have a VBAC with their next pregnancy. In the 3 years I have been doing this I have had the unique opportunity to hear hundreds of stories from women in the Valley, both their cesareans and their VBACs. Through my position I have learned a couple different things. One is that there are many unnecessary cesareans being preformed in the Valley and that women are upset about them. Another is that women do want to VBAC and some want to VBAC at home. I have seen a common theme with many of these stories. The vast majority of these cesareans were labeled FTP or CPD, even though the majority were really a failed induction. There are those who were elective due to breech or multiples and there are occasionally those who were a true emergency, but the overwhelming diagnosis is FTP and CPD. Many of these women went on to VBAC larger babies. I was happy to see that FTP was stricken from the draft of new rules as that diagnosis is often a generic label when a care provider isn't sure what it is holding up labor and it is unlikely to be repeated in a subsequent pregnancy. I would like to ask that CPD also be stricken. It is currently listed as a restriction in R9-16-109. B (5) (b) Cephalopelvic Insufficiency</p> <p>Anecdotaly it has been seen time and again that this diagnosis is mostly used as suspect rather than evidence based and women given this diagnosis often go on to birth babies, whether they are larger, smaller or the same size, with no problem. Understanding the physiological process of birth it would be more prudent to think that the previous birth was a result of malposition or simply needing more time. CPD as a cesarean diagnosis is so overused that studies have been done to prove it should not be used as an exclusion to women wanting to VBAC with their subsequent babies. An article published on PubMed.gov titled "First delivery after cesarean delivery for strictly defined cephalopelvic disproportion." states "Eighty-four of 42,793 women met the criteria for disproportion, and 40 with cephalic presentations delivered their next baby in our hospital. All 40 underwent a trial of labor and 27 (68%) delivered vaginally, comprising seven (47%) women with larger second and 20</p>	<p>Mon, Apr 8, 2013</p> <p>10:09 AM</p>

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<p>(80%) with smaller second babies. Of 15 women previously delivered by cesarean at full dilatation, 11 (73%) delivered vaginally with no serious maternal or neonatal morbidity. CONCLUSION: The strictly defined diagnosis of nulliparous cephalopelvic disproportion should not constitute an automatic "recurrent" indication for elective cesarean delivery, because 68% of patients in our series had successful vaginal deliveries in their next pregnancies. This rate is similar to those reported after all nulliparous cesareans for dystocia." Impey L. and O'Herlihy C. First delivery after caesarean delivery for strictly defined cephalopelvic disproportion. Obstet Gynecol 1998;92:799-803.  <a href="http://www.ncbi.nlm.nih.gov/pubmed/9794672">http://www.ncbi.nlm.nih.gov/pubmed/9794672</a> Based on my personal experience with women in the Valley and in conjunction with this evidence based study that shows a majority of women previously diagnosed with CPD able to birth vaginally, I request that CPD as shown in R9-16-109. 5 (5) (b) be stricken from the new rules. Thank you. Stephanie Stanley</p>	
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>As a mom planning to attempt a VBA2C in the future, I would like to have the choice to labor and deliver my baby at home with the support of a trained midwife. We have had wonderful, supportive midwives for the births of our two children, we feel that they have the most education and experience with the natural birth we desire for our third baby. My husband and I are both college educated and plan to pay out of pocket for the cost of a home birth. We carry health insurance for our family, however we rarely use its coverage, instead we seek care from alternative medical professionals and pay cash. Thank you for your consideration, Anne-Marie Chun Phoenix, AZ</p>	<p>Sun, Apr 7, 2013</p> <p>2:53 PM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Section R9-104-16 section B: This section should be removed from the rules in its entirety. A midwife, if licensed, should not be required to have a hospital or physician "on call", so-to-speak. The location of any services provided by one of the two, and thus outside of a midwife's scope of practice, will depend on the client's location and preferred care provider-something not determined by a midwife. It also degrades the professional licensure of midwifery by purporting that she/he needs back-up, when such a requirement does not exist for other providers.</p>	<p>Sun, Apr 7, 2013</p> <p>1:37 PM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Please allow VBACs for mother's who's cesarean previous diagnosis was CPD or Failure to Progress. As a Mom who had a CS due to CPD/Failure to Progress (top diagnosis for CS), and went on to have one successful VBAC, this may make it impossible for me to have my next baby at home with a licensed midwife. I would consider an unassisted birth if I was unable to have a licensed attendant. Thank you, Caitlyn Szymanski - 480-559-0531</p>	<p>Sun, Apr 7, 2013</p> <p>12:48 PM</p>

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<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Women are left with fewer and fewer choices regarding their bodies and reproduction today. When it comes to birth, I think it only logical to allow a woman to choose the healthiest scenario for her unborn child. In very few circumstances are hospital deliveries actually less risk-laden and "healthier" than homebirth. Regardless of that fact, women can choose to go to the hospital even when it's unnecessary. They can choose medicines to make a natural process a scheduled and induced one. So why then would we consider limiting the choice for women to let a naturally occurring event take its course and deliver in a safe and natural environment? As someone who is expecting a child in two weeks and has toured multiple hospitals and had two different OBs I can tell you that my experience with my midwife has been far better than anything else the medical community has offered. I chose an OB listed as a Top Doctor in Phoenix Magazine. He was prescribing medication that the FDA has said is not safe during pregnancy and that the Physician's Desk Reference says should be used to treat symptoms, none of which I had. My duty as a responsible parent-to-be is to ensure the safety and health of my child so I switched providers. I then went to an OB referred by my internal medicine doctor at Mayo Clinic. Although I felt more comfortable with her, again there were unnecessary procedures suggested that put the health of my child at risk. Not willing to put my unborn child's health on the line for a doctor's peace of mind or worries about malpractice suits, I opted to switch my care to a licensed midwife. I have learned more about the birthing process and what is normal and necessary though her than I ever did in my 5 minute OB visits. I trust this person to ensure that I and my baby are healthy. Now I have nothing against mothers who seek doctors for their care. In fact, if that's what they feel is best, I encourage it! Why? Because the fact that we have choices is amazing. It is what makes our society privileged and free. Homebirth, birth center, hospital birth or emergency birth are all completely valid and legitimate ways of bringing new life into this world. No one, especially not a law, should tell a woman how or when or where to birth. The less influence government has over something so entirely sacred, the better off we shall be. I ask that homebirth be a respected and honored choice for all women.</p>	<p>Sun, Apr 7, 2013</p> <p>7:36 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Under the sections on vbac and multiples, the exclusion of women who have had a previous breech presentation or a previous multiple gestation is inappropriate. Barring certain rare maternal anomalies that would be detected via ultrasound, these are not necessarily repeating situations.</p>	<p>Sat, Apr 6, 2013</p> <p>11:58 PM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Director Humble, I am writing you because I am concerned over the direction of the Midwifery Scope of Practice meetings. The entire reason this committee was formed is to lessen the regulatory burden placed on midwives. So far, what I read in the draft rules increases regulatory burden by creating rules that are currently not in existence. This is not what consumers want. I understand that one big point of contention is the regulation surrounding home birth after cesarean (HBAC). I think it is important to note that when a woman has had a prior c-section, her choices are limited. She is forced to choose between all of the</p>	<p>Sat, Apr 6, 2013</p> <p>6:37 PM</p>

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<p>risks (and there are many) of subjecting herself to a repeat major abdominal surgery, or the risks of attempting a VBAC. Please note here that a woman who has had a previous c-section, does not have any options available to her that do not include some risk, hospital or not. Women who are attempting a home birth after cesarean have weighed their options, evaluated risk, and determined for themselves that a home birth attended by a competent care provider (such as a Certified Professional Midwife) is the best and safest option for her and her baby. As a home birthing woman in Arizona, here are parts of the draft that I specifically would like to see amended: R9-16-108-E-2 - I object to the 25 mile limitation on home birth. Women residing in rural areas should not be precluded from having a birth at their home, assuming they are low risk. A woman should be allowed to evaluate for herself her comfort level with her proximity to the nearest hospital. R9-16-109-A-16 - Rupture of membranes commonly occurs more than 24 hours in advance of delivery. A woman should not be risked out of home birth for membrane rupture so long as she does not develop a fever and does not indicate any signs of infection. R9-16-109-B-2 - The number of prior cesareans that a woman has undergone should not be relevant to her ability to home birth. So long as she remains low risk throughout her pregnancy she should only be subjected to the same requirements as a woman who has had one prior cesarean. R9-16-109-B-5-9 - The circumstances surrounding a woman's previous deliveries do not determine the outcome of her subsequent deliveries. Only the low-risk status of the current pregnancy should determine a woman's eligibility to home birth, not the circumstances surrounding her previous deliveries. I have watched each of the scope of practice meetings, and what is most concerning to me is that very little progress seems to have been made over the course of these meetings. The department seems to be seeking some sort of consensus between midwives, consumers and OBs. Such a consensus is not likely to be achieved. Ultimately what this issue comes down to is whether a woman is going to be legally allowed to make her own autonomous health care decisions in Arizona, or whether those decisions are going to be forcibly made for her by the medical community. Women are going to continue to birth at home, even women with previous cesarean deliveries, regardless of the decision made by the department. The department's responsibility here is to make sure those women have legal access to competent care providers to oversee these home deliveries. Thank you for your time.</p>	
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>here is a link to the archives of the Canadian Peer Reviewed Midwifery Journal, there are some articles that include home vbac attendance <a href="http://ojs.library.ubc.ca/index.php/cjmrp/issue/archive">http://ojs.library.ubc.ca/index.php/cjmrp/issue/archive</a></p>	<p>Sat Apr 6, 2013</p> <p>2:28 AM</p>
<p><b>1. The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>In response to how midwives will aquire the new skills, by working with other providers or midwives who do have the skill set- there are CPMs, CNMs , Naturopaths and a few retired professionals who have proficiency in delivery of breeches,vbacs and twins. I spoke with a few Arizona CPMs on Thursday that have trained in other states or countries and have the ability to attend these births starting right away. The way that it would be taught is that with clients permission they would be attended by the skilled midwife and trainee(s) for either observation of technique or supervision of the techinque, until the deemed proficent. I am currently putting together a midwife skills survey to find out who is willing to train other midwives.</p>	<p>Sat Apr 5, 2013</p> <p>11:36 AM</p>

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<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>True story-mom is unsure she is in labor. Midwife heads over to check on her and be on the safe side. Midwife walks in, gets FHR and mom says she feels pushy. Ok, midwife gloves up and out comes baby. Midwife in attendance 8 minutes before baby, some of that time is setting up emergency equipment for the small chance of emergency. Where in this real scenario would the midwife have time to call the local l and d charge nurse. Will the midwife get in trouble for not calling or would midwife have to call after and say-had a precipitous birth-just wanted to let you know? When I am on my way to a birth, I am thinking of the safety of my client and her baby--nothing else matters as I am trying to get my head in the game. Making midwives call to report a women in labor puts moms and babies at risk because their midwife is being required to do other tasks which have nothing to do with home birth. It would only satisfy a requirement imposed by the department heads who ever never been to a home birth. If a transport becomes necessary I always call ahead and tell them when and why we are coming. Also if this is just to build bridges, there is a midwifery group, that brings a holiday gift to local hospitals every year along with info about LM's. Along with the semi annual Midwives and Doulas teas at Mercy Gilbert Hospital and other community events hosted by an Mesa OB and Gilbert CNM practice, there will also be a community gathering to further bridge the gap between home and hospital midwives. Please know that LM's are always looking for ways to form relationships with doctors, hospitals and their staff, and they do that with out being required too. Please strike this from the rules as it has nothing to do with giving moms and babies safer care.</p>	<p>Thur, Apr 4, 2013</p> <p>10:08 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>To address the need for midwife to call in to the OB charge nurse at the beginning of labor and all clear at the end of labor.I believe if this is a requirement on the midwives part, then it should be written into the rules for nurses at the hospital. If they have this as a requirement it will make the transition much more smooth. Some midwives are in communities where our hospital is not tolerant of midwifery care.</p>	<p>Thur, Apr 4, 2013</p> <p>10:04 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>Under prohibited practice and transfer of care. Page 19 section B. # 5. a . failure to dilate.. I believe there should be a clause or addition that recognizes if A previous C-section was the result of failure to dilate due to fetal head mispresentation such as military presentation or direct OP, this is not likely to present again in other pregnancies . Same section #8 and #9 prohibited to allow V-BAC for previous multiples and previous breach births. I find in no research that this to be a risk factor...In fact ACOG's own recommendation for V-BAC actually states that in non reoccurring indications, such as (previous) breech, placenta previa or herpes a V-BAC has much more chance of success... Why would we put a</p>	<p>Thur Apr, 4 2013</p> <p>9:37 AM</p>

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burden on our clients that ACOG does not even recognize as a risk factor?	
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I am very concerned about (Name removed by editor) being on the board. She has repeatedly stated she is not in favor of increasing the scope of practice. Therefore she is not going to listen to anything that is being stated and she actually gets hostile during the meetings. The midwives just need better rules and should not have to go up against such hostility in order to provide better care to women. We cant force her to have an open mind, but she should be able to control her anger. Thank you.</p>	<p>Thur Apr 4 2013</p> <p>7:58 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>in watching the meeting, if it is the case that western medicine has done so well at protecting the safety of pregnant mothers and children why does the united states have such poor statistics. i am not sure what the efficacy of having a doctor (Name removed by editor) i believe her name was) who is so openly hostile to the home birth process; is to accomplishing the revised rules to allow for the expanded practice of midwives. because obviously since homebirth is only accounting for a small percentage of births, maybe this is the way to do it right, without interventions, and without fear because most of the stats refer to doc led birth</p>	<p>Thur Apr 4, 2013</p> <p>6:06 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>As a VBAC mom, who has SUCCESSFULLY had a vbac, I find it extremely upsetting that in a future pregnancy, I could not be assisted by the practitioner of my choice. I am educated, I'm not naive. My choice was taken away by an over-zealous MD who did not check on me when I was induced and nurses who, in the hospital, did nothing to assist me in labor. The OB did not physically check on me except when she inserted the cervix ripener and then once 24 hours later. In that time no one noticed my daughter was slightly transverse. My options to even WALK to assist the baby to get into a good position was taken away. I was laughed at when I came in with a birthing ball. I was bullied into agreeing to a cesarean and now MY choices are limited? How fair is that? To make matters worse, my induction was possibly unnecessary per an OB who I saw originally during my VBAC pregnancy, I later changed to a hospital-based midwife, but would have preferred a home birth, but was unable to do so due to the law. Oh, the original "OB" group has disbanded - hopefully fewer women are being bantered because of that, but most likely not. So, because I trusted licensed medical practitioners originally, I'm at a disadvantage to having a birth of my choosing? At minimum, consider the difference between a woman who has given vaginal birth against one who hasn't.</p>	<p>Thur Apr, 4 2013</p> <p>3:36 AM</p>

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<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I respectfully submit that the department of health needs to put into rule the use of standard of practice emergency medications for licensed midwives. This would increase the safety of women during the treatment of postpartum hemorrhage and the transfer of care for severe hemorrhage. Opening the language to include a class of drugs, anithemorrhagics, allows the law to naturally evolve with changing medical advances. As an out-of-hospital birthing woman, I want the safety net of knowing my midwife can halt a hemorrhage to get me to the hospital. If a hemorrhage is treated and resolved early, the impact on a woman's health is significantly reduced. I also request that it be put into rule specifically so that my midwife cannot be charged with practicing medicine without a license. Allowing this to be included in the scope of practice means that if a drug is used incorrectly, the midwife can face disciplinary action similar to that which a doctor or certified nurse-midwife would face: peer review, censure, fines/fees, and potential loss of license to practice.</p>	<p>Thur Apr 4 2013</p> <p>12:39 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I would like to see the midwifery advisory committee look more like the council proposed in the midwives' submitted report. The midwives should be allowed to be self-governing, as other classifications of care providers do. A volunteer council would also save money for the state of Arizona. 1. Addition of Midwifery Advisory Council. An ongoing volunteer Midwifery Advisory Council is adopted to create a more informed regulatory Department. The current process of simple rules enforcement focuses on whether the midwife can follow the written rules, as opposed to recognizing that the midwife can make sound, up to date, evidenced based care decisions specific to each midwifery client she encounters. The Midwifery Advisory Council would be composed of Arizona licensed midwives and midwifery consumers. From an educated, peer review perspective, and inclusive of consumers as important stakeholders, responsibilities would include: reviewing current evidence, evaluating complaints, advising the Department on all future rules and statute changes, processing disciplinary actions, interpreting the rules, and assisting the Department in staying current on research and statistics. Five midwives would sit on the council, duly representing all Arizona midwives and ensuring an objective and intimate working group. Random rotation is important so that objectivity is maintained, and, therefore, all LMs have the opportunity and responsibility to sit on the council."</p>	<p>Thur Apr 4 2013</p> <p>12:20 AM</p>
<p><b>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</b></p> <p>I appreciate everything you are doing to try to evaluate how to best serve women and I truly feel you are doing your best. In that being said, I believe that it's a woman's responsibility to become informed, and know her choices, and I feel that women are intelligent enough to do their research. The cost of a midwife if you break her costs up over 10 months is the same as a payment for an insurance plan. Women who see midwives are not uneducated, they are often times actually quite a bit more educated. I had my son at home with a wonderful midwife and we covered all the bases and I felt fully informed and well cared for. When I have a child again I am happy to know all the choices I have and believe VBAC, Breech, and Twin women can have the same choices with proper care as long as they are informed. Thank you.</p>	<p>Wed. Apr 3, 2013</p> <p>8:36 PM</p>

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Director Humble, Please remove the requirement of calling the charge nurse when a midwife's client is in labor. I know this is an attempt at collaboration, but true collaboration will never be achieved by mandate. This requirement will only bring bad feelings to this midwife/hospital relationship. Furthermore, as a consumer of homebirth midwifery, I would be extremely wary of my midwife if I knew she was required to tell someone other than my approved birth team (and without my consent) that I was in labor. Even if my identity is undisclosed, I must respectfully say that it is simply none of their business and I do not want it divulged. I would be less inclined to call my midwife when I need her if I knew this were the case. It also bears mentioning that merely letting my own mother know that I'm in labor disrupts my labor pattern and slows my progress significantly. Finally, this requirement does not "reduce regulatory burden" and therefore should not be included. Thank you.

Wed Apr 3  
2013

5:11 PM